Patient Safety Partnerships

The Impact of Organizational Culture

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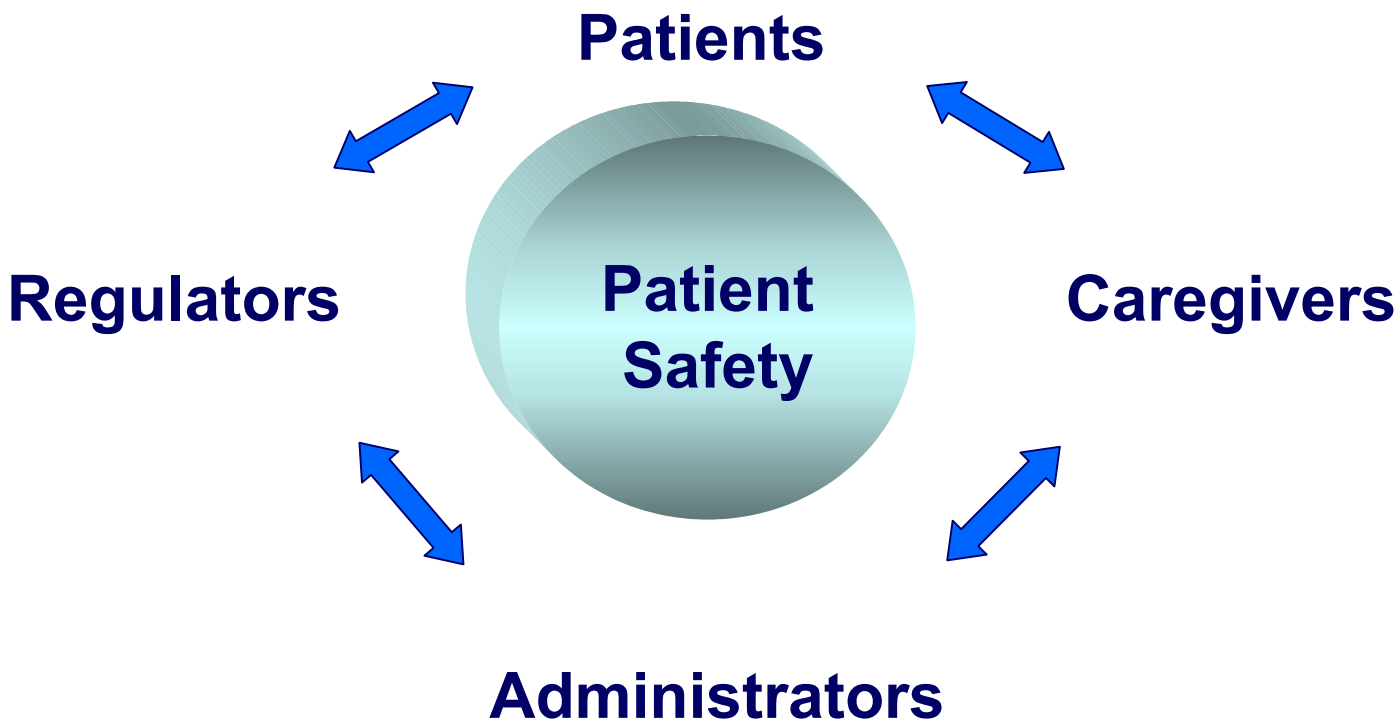
Making New Jersey a Model for Patient Safety - 8/19/03

Key Patient Safety Partnerships



Patients ⟷ Caregivers

Goal: Patients and caregivers will be pre-occupied with safety

- Both patients and caregivers:
  - understand there are risks inherent in systems
  - recognize error-prone processes
  - play an active role in preventing adverse events
  - work together to find safer ways of doing things

Caregivers  Administrators

Goal: Errors, near-misses and risks will be reported

- Caregivers feel safe reporting
- Administrators demonstrate that reports are used to improve safety

Administrators ⟷ Regulators

Goal: Adverse events will be properly investigated and findings will be used to reduce the risk of errors

- Investigations are timely, thorough, respectful and systems-focused
- Administrators and regulators utilize aggregate data to inform and shape the patient safety agenda
- confidentiality of specific adverse events is maintained

Patients ⟷ Caregivers

Goal: Patients and caregivers will be pre-occupied with safety

Action Steps:

- Use of two patient identifiers
- Root Cause Analysis and Proactive Risk Assessment
- Reconciling medications
- Executive Leadership WalkRounds
- Clinical Pharmacy rounds
- Education

Caregivers ⟷ Administration

Goal: Errors, near-misses and risks will be reported

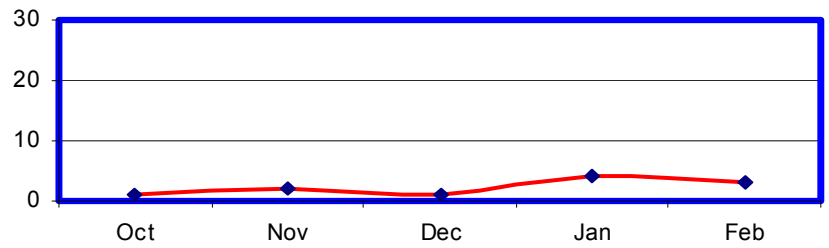
Action Steps:

- Fully endorsed non-punitive error reporting policy
- User-friendly reporting tools emphasize contributing factors
- Involve staff in adverse event investigation and follow-up
- Leadership involvement in patient disclosure and availability of counseling support
- There are built-in feedback mechanisms for staff

Potential Medication Error Reporting Project

BASELINE DATA

Potential Errors Reported by Nursing - Baseline



CAUSES (ANALYSIS OF DATA)

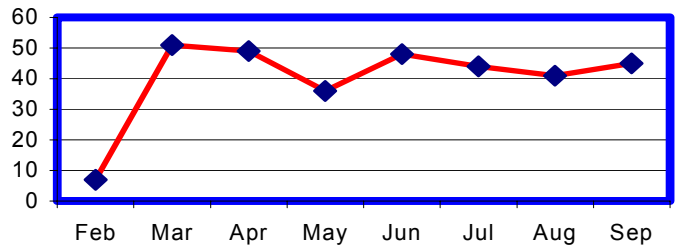
1. Medication Event Report is long and detailed
2. Inconsistent use of existing reporting tools
3. On-line charting not universally available
4. Staff have not received feedback related to reporting
5. 61% of staff report that they do not feel completely safe reporting errors or near-misses

ACTIONS TAKEN

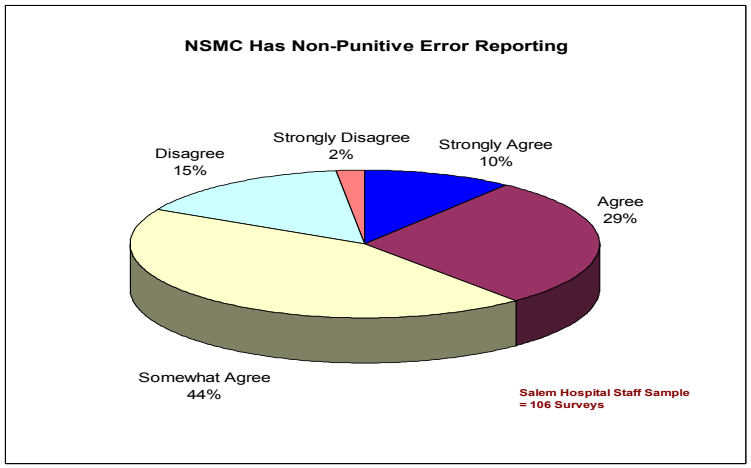
1. Survey of staff attitudes re: punitive reporting culture
2. Non-punitive error reporting policy implemented
3. Unit-based training storyboard developed
4. Post card for reporting potential errors introduced
5. Data from postcards entered into database and
6. reported out by Dept/Unit/Error Type
7. Results communicated to MERT and Depts/Units

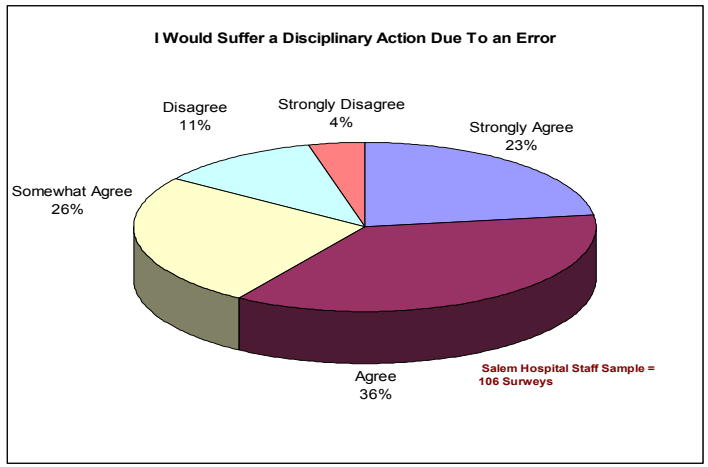
RESULTS

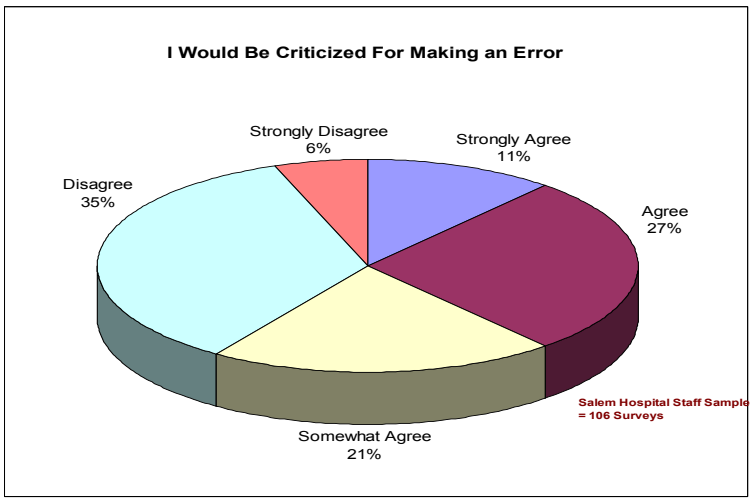
Potential Errors Reported by Nursing Feb – Sept

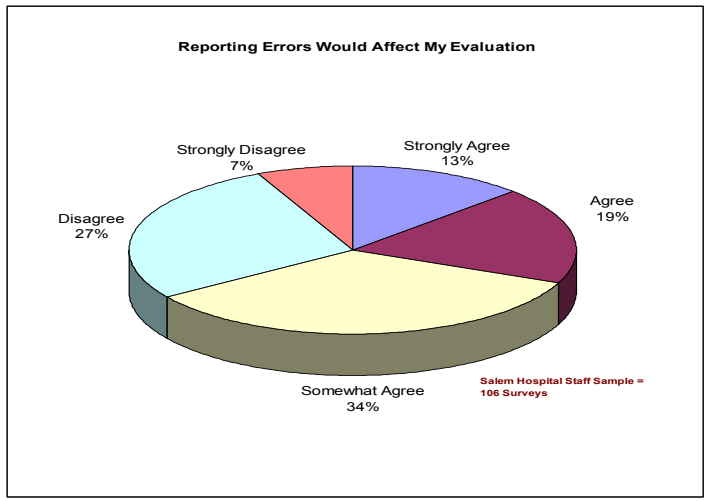


Initial Staff Attitude Survey









Potential Error Reporting – Keep it Simple

POTENTIAL MEDICATION ERROR ALERT

Date:_____ Patient:_____ Unit:_____ Shift:_____

Drug name:_____

Circle one: Wrong - drug route dose time omission

Circle one: prescribing / transcribing / dispensing / administering

What happened?_____

_____

What contributed to this near miss?_____

_____

Congratulations on identifying this patient safety risk – you have helped to make our medication system safer. Keep those cards and letters coming!

Administration ⟷ Regulators

Goal: Adverse events will be properly investigated and findings will be used to reduce the risk of errors

Action Steps:

- Standardized process for investigation with clear accountability, good communication and active involvement of all key stakeholders
- Algorithms for outside agency reporting
- Effective documentation tools are used consistently
- Outcomes are communicated and improvements celebrated

Administration ⟷ Regulators

Goal: Adverse events will be properly investigated and findings will be used to reduce the risk of errors

Action Steps (con't):

- Patient Safety is a standard agenda item at meetings of the Medical Staff leadership, executive and management teams and Board of Trustees
- JCAHO Sentinel Event Alerts and National Patient Safety Goals, Board of Registration in Medicine, FDA and CDC Safety Advisories are used to set annual goals for performance improvement